FOR NON-AVIATORS:

(Office Symbol)_____ (Date)_____

MEMORANDUM TO OIC, Wilford Hall Refractive Surgery Center

SUBJECT: Commander's Endorsement of Refractive Eye Surgery

1. I hereby give my endorsement/permission for the below listed active duty Soldier to be evaluated for enrollment in the refractive eye surgery program.

Name: _____
Last First MI
SSN: _____ **ETS DATE:** _____**DOB**_____
RANK: _____ **SERVICE:** _____
DUTY TITLE: _____ **MOS:** _____
ASSIGNED UNIT: _____
CONTACT ADDRESS: _____
CONTACT PHONE: (DAY) _____ **(EVEN)** _____
E-MAIL ADDRESS: _____

2. I realize that after the surgery, the Soldier will have the following profile for a minimum of 30 days: NO FIELD DUTY, AIRBORNE OPS, SWIMMING OR SCUBA, TACTICAL NIGHT OPS, GAS MASK, CAMMO FACE PAINT, DRIVING MILITARY VEHICLES. SUN-GLASSES MAY BE WORN AS NEEDED INDOORS AND OUTDOORS FOR 90 DAYS.

3. I further realize that the Soldier must remain CONUS for at least 30 days following PRK and 60 days following LASIK.

4. The Soldier will be on unit convalescent leave for up to 96 hours following surgery and must keep all follow-up appointments with the Optometry Clinic at LAHC to avoid potential complications.

5. The Soldier must have 12 months on station and have a minimum of 18 months active duty service commitment remaining. ETS date must be stated on identification card. National Guard and Reserves are <u>not</u> eligible for surgery under the WRESP.

I authorize the above soldier's treatment for a period of 30 / 60 / 90 (circle one) days from today **<u>OR</u>** for the specific date range of _____ through _____.

_____ _____ _____ _____
Company Commander's Signature Date Battalion Commander's Signature Date

_____ _____
Company Commander's Name and Rank Battalion Commander's Name and Rank

_____ _____
Unit Unit

_____ _____
Company Commander's Telephone and E-mail Battalion Commander's Telephone and E-mail

Aviation Commander's Authorization

Memorandum to: Unit Flight Surgeon

CC: Opthalmology, Refractive Surgeon

Subject: Authorization for Aircrew members to receive refractive surgery under the Aeromedical Policy Letter for Refractive Surgery and the Corneal Refractive Surgery Surveillance Program.

1. _____, SSN _____ is authorized to receive refractive surgery per the guidance outlined in the Aeromedical Policy Letter: Corneal Refractive Surgery/JAN 2006

2. This authorization is based on the following understandings:

a. This authorization does not constitute a medical waiver; it only authorizes the individual to have refractive surgery. The individual will be DNIF for at least 6 weeks and possibly up to 12 weeks. The medical waiver request will be submitted to USAAMA upon receipt of information from the flight surgeon as to the successful outcome of the individual's surgical procedure. USAAMA will determine if the individual's meets the medical waiver requirements when the applicant's eyes and vision meet and retain FDME standards and all requirements for waiver have been met.

b. Two to 3 of 1000 eyes (0.2 to 0.3%) will not recover 20/20 best-corrected vision after refractive surgery. Individuals who fall in this category will be evaluated by USAAMA to determine whether a waiver to continue on flight status may be issued. Although slight, there is a possibility the individual may lose his/her flight status in the case of significant visual loss that cannot be resolved.

c. Questions about the study may be directed to USAARL at 334-255-6810, about waivers to USAAMA at 334-255-7430, and about refractive surgery to the local eyecare provider.

d. A copy of this correspondence will be kept on file in the local flight surgeon's office.

3. POC is the undersigned at _____.

Commander's Signature Block

FOR ALL CANDIDATES:

Commander's Authorization
Warfighter Refractive Eye Surgery Program (WRESP)

1. I hereby give my endorsement/permission for the following Soldier to be evaluated and considered for enrollment in the WRESP and for their PRK/LASIK eye surgery if eligible.

Name: _____ **Rank:** _____
Last, First, MI

SSN: _____ **ETS Date:** _____ **MOS:** _____ **Duty Title:** _____

Assigned Unit: _____

Contact Address: _____

Contact Phone: (day) _____ **(evening)** _____

E-mail address: _____

Likely to do travel for the following reasons in the next 4 months? (please circle) PCS Deploy TDY School **Projected date (if known):** _____

2. I certify that the following are true and will inform local MTF eye clinic if Soldiers circumstances change:
   a. Soldier has 18 months remaining on Active Duty
   b. Soldier has no adverse personnel actions pending
   c. Soldier will remain CONUS for at least 60-90 days

3. I realize that after surgery, the Soldier will have up to 4 days of convalescent leave. In addition, I understand that the SM will have the following profile for a minimum of 30 days:
   a. No field duty or driving military vehicles
   b. No organized PT – may do modified individual PT
   c. No swimming, protective mask use, or use of camouflage face paint
   d. May wear sunglasses at all times

4. I further realize that participation in this program requires a considerable investment of time resulting in absences from duty and will ensure that the Soldier will keep all appointments. Minimum requirements are as follows:
   a. Initial evaluation (local medical treatment facility (MTF)) – up to half a day
   b. Surgery – one week off work, up to two weeks, especially if Soldier has to travel for surgery
   c. Postoperative evaluations (local MTF) – normally scheduled 1, 5, 30, and 90 days after surgery

5. I understand that if Soldier needs to travel to another facility to receive refractive surgery, all TDY costs will be incurred by the Unit or the Soldier receiving the elective refractive eye surgery.

Company Commanders Signature	Battalion Commanders Signature
Company Commanders Name and Rank	Battalion Commanders Name and Rank
Date / Phone	Date / Phone
Company Commanders Email Address	Battalion Commanders Email Address

Corneal Refractive Surgery Checklist for Eye Care Provider

Last name: _____ First name: _____ Middle initial: ____
Mailing Address: _____
_____
E-mail Address: _____
Home/Mobile Phone: _____
Date of Birth_____ SSN_____

Eye Care Provider
Surgeon/Doctor's Name: _____
Clinic address & telephone: _____
_____
_____

Specific procedure details (Operative and Pre-Operative Data)

Date of Procedure: _____ Type (circle one) PRK or LASIK
Laser Used (manufacturer):_____ (model #) _____

Ablution parameters (Complete below, or if available, attach copies of laser records.)
OD: Size of ablation: _____*mm* Tissue removed: _____ *microns* # of Pulses: ___
OS: Size of ablation: _____*mm* Tissue removed: _____ *microns* # of Pulses: ___

Amount of correction programmed into laser:
OD: _____ OS: _____

Pre-operative Refraction
OD: _____ OS: _____

Did the applicant require any enhancement procedures? Yes _____ No _____
(If yes, please provide details above)

Post Operative Data:
Follow-up examinations (include most recent and 2 prior examinations(3 total))

DATE	REFRACTION	VISUAL ACUITY	CORNEAL HAZE* (circle one)
	OD: OS:	OD: OS	OD: 0 1 2 3 4 OS: 0 1 2 3 4
	OD: OS:	OD: OS:	OD: 0 1 2 3 4 OS: 0 1 2 3 4
	OD: OS:	OD: OS:	OD: 0 1 2 3 4 OS: 0 1 2 3 4

*** Haze 0-4 scale.** 0=no haze. 1=trace, 2=minimal, 3 moderate, 4=iris details obscured.

Checklist for Eye Care Provider (post operative cont.) Page 2 of 2

Corneal topography (post operative, include a *color* copy of most recent *post-operative* corneal topography using the
TANGENTIAL or INSTANTANEOUS map display option)
Manufacturer: _____
Model: _____
Date of topographies: _____

Contrast Sensitivity (attach copy of post-operative results, if available)
Test Manufacturer & Model: _____
Date of contrast test: _____
Test Conditions:
Room Lights ON (Circle one) Yes No
Backlit Chart (circle one) Yes No
Distance to test _____*m*
% Contrast (if letters) _____%
Results:
OD: _____
OS: _____

Does applicant report any subjective visual changes? (i.e. increased glare, starbursts, halos, etc.)
_____
_____

***For Class IA/1W** (MUST complete a post-operative cycloplegic refraction, noting normal refractive DVA/NVA with
best correction, and IOP's if your 1A/1W FDME data was pre-operative.)

Distant Visual Acuity Near Visual Acuity
OD 20/_____ Corrected to 20/_____ OD 20/_____ Corrected to 20/_____
OS 20/_____ Corrected to 20/_____ OS 20/_____ Corrected to 20/_____

Cycloplegic Refraction:
OD: _____
OS: _____
Pre-Operative Intraocular Tension: OD _____ OS _____

Please return this form and supporting documents to your Flight Surgeon.